Town of Essex – Health Department
29 West Avenue, Essex CT 06426
860-767-4340 x 118

Evacuation Registry For Citizens with Special Needs

The Health Department and the Essex Emergency Management Director maintain a database of seniors and people with special needs who may require evacuation and shelter assistance during a natural or a man-made disaster.

Citizens with medical disabilities or transportation needs can pre-register with the Town of Essex Health Department who may need help in case of an emergency evacuation.

Citizens who register will be asked to keep their information current and update it annually. Registration documents will remain confidential in accordance with state and federal law, and will be maintained by the Essex Health Department. Data will be used by emergency personnel only to help during preparedness planning and required evacuations.

The registration form is attached. The form is also available on the Essex Health Department website (www.essexct.gov), from home service providers (e.g. Meals on Wheels, FISH, Visiting Nurses etc.), town libraries and the Essex Ambulance Association.

Completed forms should be mailed to:
Essex Health Department, 29 West Avenue, Essex, CT 06426.

Questions or concerns may be directed to the Health Department at (860) 767-4340 x 119.

Registration Instructions:

A separate form is required for each individual person requesting evacuation registration.

Answer ALL questions.

If your form is missing information (such as correct phone number, address, etc.) we may not be able to contact you. We cannot determine your needs unless you answer ALL questions regarding any medical and transportation requirements. Upon receipt of your completed form, you will be entered into our restricted database.

Keep your registration information current.

You are responsible for informing the Health Department of any changes that may affect your registration records. If you move, change your phone number, or no longer need to be registered, let us know immediately so your file information can be updated. If we cannot contact you during an emergency evacuation, we cannot assist you.

This registry will be updated annually.

New forms will be mailed to registrants to update information and verify eligibility. Registrants who DO NOT reply or cannot be reached will be removed from our registry.

Registration is **FREE** and **VOLUNTARY.** This form is solely to provide information for a registry to be used by those public health and safety agencies who may be asked to assist during an emergency evacuation. It does not imply or guarantee any other service.

ESSEX EMERGENCY PLANNING AND EVACUATION FORM

The Essex Health Department and Emergency Management is developing a registry of seniors and people with special needs who might need evacuation and shelter assistance during public health emergencies or natural disasters. The information you provide will be confidential. It will be used by emergency planning and evacuation personnel only. Please fill out the registration form and mail it in to the Essex Health Department, 29 West Avenue, Essex CT 06426. If you have additional questions please call the Health Department 860-767-4340 x 118.

PLEASE PRINT OR TYPE

WHO YOU ARE

First Name_____ Middle Initial_____ Last Name:_____

Date of Birth:_____

Sex: ☐Male ☐Female

English Spoken: ☐Yes ☐No if "no" what is your primary language_____

RESIDENCE INFORMATION

Location:_____ ☐Essex ☐Ivoryton ☐Centerbrook
Street No. Street Name Apt No.

Do you live in a ☐Single Family House ☐Apartment ☐Condo ☐Rest Home/Assisted Living Facility

Phone No:_____ Alterative No:_____TDD/TT:_____

Do you live by yourself? ☐Yes ☐No

If no, who lives with you? ☐Spouse ☐Family Member ☐Caregiver ☐Companion

Their Name(s)_____

Would this individual be capable of assisting you during an emergency? ☐Yes ☐No

If you are a part-time resident (i.e. summer only), please list the months you reside at this location

_____

If no, do you have a primary care giver name:_____ Phone No._____

Relationship to you:_____

Does a caregiver live with you? ☐Yes ☐No

Are you seen by a health aide or a visiting nurse? ☐Yes ☐No

If yes, number of visits per week:_____

Other describe:_____

Do you have any pets?☐ Yes ☐No If yes, please give the name, type and weight of the animals

_____

EVACUATION PLANNING

If ordered to evacuate, do you have an evacuation plan? ☐Yes ☐No

Do you have a car? ☐Yes ☐No

Do you drive? ☐Yes ☐No

Do you have someone to drive you? ☐Yes ☐No

If no, will you go by: ☐wheel-chair van ☐ambulance ☐other_____

If ambulance, name of ambulance company:_____Phone No:_____

Will your companion/spouse/caregiver go with you? ☐Yes ☐No

Name:_____ Relationship_____

Will you need assistance to evacuate to a shelter? ☐Yes ☐No

SHELTER PLANNING

What is your plan for shelter if evacuation is necessary?_____

_____

If no plan would you like the Essex Office of Emergency Management to contact you? ☐Yes ☐No

SPECIAL CONDITIONS

Elderly/frail	☐Yes	☐No
Difficulty walking	☐Yes	☐No
Blind or sight impaired	☐Yes	☐No
Deaf or hearing impaired	☐Yes	☐No
Mental disability	☐Yes	☐No
Memory impaired	☐Yes	☐No
Diabetic	☐Yes	☐No
If yes, insulin dependent?	☐Yes	☐No
Pills?	☐Yes	☐No
No treatment	☐Yes	☐No
Cardiac problems	☐Yes	☐No
Respiratory problems	☐Yes	☐No
Paralysis	☐Yes	☐No
Allergies	☐Yes	☐No

If yes describe;_____

Other conditions:_____

TREATMENT/EQUIPMENT

Do you take prescription medications ☐Yes ☐No

If yes, do you have a current list of medications? ☐Yes ☐No

Respirator ☐Yes ☐No

Foley Catheter ☐Yes ☐No

Oxygen ☐Yes ☐No

If yes, supplier name/type of equipment or machine_____

Oxygen Usage: ☐Continuous ☐part-time Oxygen _____ liter flow

Tracheotomy ☐Yes ☐No

Dialysis ☐Yes ☐No

Home Dialysis ☐Yes ☐No

Intravenous Line ☐Yes ☐No

PICC line/Hickman Catheter ☐Yes ☐No

Feeding Tube ☐Yes ☐No

Other emergency equipment:_____

AMBULATION CAPACITY

Are you confined to a: ☐Bed ☐Wheel Chair ☐Power Wheel Chair

Do you use a: ☐Wheel Chair ☐Walker ☐Cane ☐Service Animal

Other assistance needs:_____

IMPORTANT NAMES AND PHONE NUMBERS

Physician Name:_____ Phone No.:_____

Hospital Preference:_____

Home Health/Hospice Name:_____ Phone No._____

Pharmacy Name:_____ Phone No._____

Care Giver/Visiting Nurse Assoc Name:_____ Phone No._____

Comments/Notes:_____

_____

_____

PERSON/RELATIVE CONTACTS

Please indicate if we can release your evacuate status to a contact person or relative.

Release status information: ☐Yes ☐No

To whom?

Name:_____ Phone No.:_____

Relationship:_____